State of California - Health and Welfare Agency **Department of Alcohol and Drug Programs**

Direct Contract Provider
MONTHLY INTERIM PAYMENT CLAIM
for Drug/Medi-Cal (D/MC) State General Funds (SGF) - Fiscal Year 1998-99

County: _____	NAME AND ADDRESS _____ _____ _____ _____ _____
CHECK ONE FOR EACH LINE:	
[__] Non-Perinatal (20) [__] Perinatal (25)	
[__] Non-Minor Consent [__] Minor Consent	

ADP Contract # _____	D/MC Provider #: _____	Mo/Yr of Claim _____

NARCOTIC TREATMENT PROGRAMS (NTP)

Type of Service	SFC	Projected Units of Service	Cost Per Unit of Service	NET CLAIM
Methadone	20-22			
LAAM	23-25			
Individual Counseling	26-27			
Group Counseling	28-29			
FEDERAL AND STATE SHARE SUB-TOTAL				

OTHER DRUG/MEDI-CAL MODALITIES

Type of Service	SFC	Projected Units of Service	Cost Per Unit of Service	NET CLAIM
Day Care Habilitative	30-39			
Outpatient Drug Free - Indiv.	80-84			
Outpatient Drug Free - Group	85-89			
Naltrexone	50-59			
Perinatal Residential	40-49			
FEDERAL AND STATE SHARE SUB-TOTAL				

GRAND TOTAL (Federal and State Share) - NTP & Other Drug/Medi-Cal Modalities	

Signature of Fiscal Representative	Date
Typed Name of Fiscal Representative	Telephone Number

ADP PROGRAM CERTIFICATION

I hereby certify that this request is in accordance with the existing contract and is approved for payment.

TOTAL STATE GENERAL FUNDS (48.77% for 7/1/98 to 9/30/98 and 48.45% for 10/1/98 to 6/30/99 - Except for Regular Alcohol/Drug Minor Consent(*)	

ADP Analyst Approval	Date

ADP Form 7890 (7/98) (*) Minor Consent - See back for Information

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